ABSENTEE SHAWNEE TRIBE OF OKLAHOMA
OFFICE OF INDIAN CHILD WELFARE
2025 SOUTH GORDON COOPER DRIVE
SHAWNEE, OK 74801
405-275-4030 800-256-3341 FAX: 405-214-4238

INCOME VERIFICATION

I hereby give my permission to release information on my income status to the above program for participation in the Foster Care Program.

I understand that this information will only be used by this program and will not be released to any other agency or organization without my consent.

Name: _____ SSN#: _____

Address: _____

Home Phone: _____ Work Phone: _____

Signature: _____ Date: _____

*****THIS PORTION TO BE COMPLETED BY EMPLOYER*****

Employer: _____

Address: _____

Employed From: _____ To _____ Occupation: _____

( ) Permanent ( ) Temporary ( ) Part-Time ( ) Full-Time

Current Base Pay Rate: $ _____ per _____ Effective: _____

Average # of hours per week: _____ Overtime Rate:_____Per_____

Pay Period: ( ) Weekly ( ) Bi-Weekly ( ) Monthly ( ) Other _____

Actual amount earned during the past 12 months or for period of employment, if less than 12 months:
$ _____ Dates: From _____ To _____

Number of overtime hours for the above period: _____

Your estimate of anticipated total earnings in the next 12 months: $ _____

Signature of Official _____ Date: _____

Title: _____ Phone: _____